DELTA DENTAL®

TUFTS Health Plan

Under Age 19 Plan Benefits Summary (PPO ADVANTAGE SAVER MA)

This is a summary of benefits. Refer to the Evidence of Coverage for a full description of the plan provisions. To be covered, services must be dentally necessary and appropriate as per our review guidelines. Visit www.deltadentalma.com/ppo-find-a-dentist/ to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-844-260-6095.

Deductibles: Apply to certain services
Annual Maximum: None
Medically Necessary Orthodontic Lifetime Maximum: None
Maximum Lifetime Cap: Unlimited
Please refer to your Tufts Health Plan Summary of Benefits and Coverage for information about your out-of-pocket maximum and deductible.

Procedure	Frequency/Limitations†	In Network	Out of Network ***
Diagnostic		100%	80% **
Oral exam	Twice per policy year.		
Comprehensive exam	Once per lifetime per dentist location		
Bitewing x-rays	Two sets per policy year		
Complete x-ray series and panoramic film	Once every 36 months		
Single x-rays	Limitations apply		
Preventive		100%	80% **
Cleaning	Twice per policy year		
Fluoride treatment	Once every 3 months		
Sealants	Once every 36 months on unrestored molars		
Space maintainers			
Minor Restorative		75% **	55% **
Amalgam (silver) fillings	Once per 12 months per tooth surface		
Composite (white) fillings	Once per 12 months per tooth surface		
Rebassing or relining of partial or complete dentures	Once every 24 months		
Recommending crowns and onlays			
Major Restorative		50% **	30% **
Crowns (over natural teeth when teeth cannot be restored with regular fillings). Stainless steel crowns are covered at a different coinsurance amount. *	Replacement limited to once every 60 months		
Endodontics		75% **	55% **
Root canal therapy on premanent teeth	One procedure per tooth per lifetime		
Vital pulpotomy	One procedure per tooth per lifetime		
Apicoectomy	One procedure per tooth per lifetime		
Periodontics		75% **	55% **
Root planning and scaling *	Once per quadrant every 36 months		
Prosthodontics		50% **	30% **
Partial and complete dentures *	Replacement limited to once every 60 months		
Extractions and Oral Surgery		75% **	55% **
Simple extractions not requiring surgery			
Surgical extractions and other routine oral surgery when not covered by a patient's medical plan			
Orthodontics		50% **	30% **
Medically necessary braces and related services * **Requires prior authorization.** No payment will be made if not obtained.	Covered only when medically necessary; patient must have severe and handicapping malocclusion as defined by HLD index score of 22 or higher and/or one or more auto qualifiers.		
Other Services		75% **	55% **
Palliative treatment (minor procedures necessary to relieve acute pain)			
General anesthesia or intravenous (I.V.) sedation			

Dependent children are covered under these benefits up until the end of the month they turn age 19.

* Indicates Pre-treatment Estimate recommended/Prior Authorization as required.
** Indicates Deductible applies to this procedure.
*** Out-of-network care: This is the amount Delta Dental pays. For services received out-of-network, your costs will be greater because non-participating dentists are paid at a reduced level. Please refer to your Certificate of Coverage for further details.

† Time Limits on services (e.g. 6, 12, 24, 36, or 60 months) are computed to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it would not be covered again until the following year on July 2 or after.

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